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This study was conducted to determine if Track II treatment for alcohol and drug abuse provided by the Fort Leonard Wood ADAPCP is successful six months after discharge from treatment. All soldiers released from the Track II program for one quarter of calendar year 1984 were followed up through unit commanders to assess their success rate. Of 45 cases, 18 had been classified failures and had been discharged from the Army, eight soldiers classified as successes were no longer on Ft Leonard Wood due to PCS and ETS, and 19 were still performing their previous duties. The author counted all soldiers classified as failures and all soldiers that had ETSed as failures, leaving a success rate of 48.9 percent. *Keywords: Health Care Administration*

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TRACK II TREATMENT
AT
FORT LEONARD WOOD, MISSOURI

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Submitted to the Faculty of
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of
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by
Major Ralph R. Hadley, MSC
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I. INTRODUCTION

The Army ADAPCP

On 28 September 1971, Public Law 92-129 mandated a program for the identification and treatment of alcohol and drug dependent persons in the Armed Services. This law came into existence as a result of many factors but primarily due to the number of returning Vietnam veterans who were experiencing significant problems with alcohol and drugs. Additionally, there was considerable use of drugs in the civilian community which was gaining national attention. As a result of this public law, the U.S. Army instituted a program to prevent and control the abuse of alcohol and other drugs.

The Army's initiative, the Alcohol and Drug Abuse Prevention and Control Program (ADAPCP), is defined as a manpower conservation program and is comprised of several functional areas. These areas include prevention, education, identification, rehabilitation, treatment, program evaluation and research.¹

The ADAPCP is considered a Commander's program and Commanders at all levels have the responsibility for implementation. Primary involvement is at the company or unit level where the Commander is responsible for identification, referral and enrollment of soldiers who need care through the treatment or rehabilitation efforts.

The prevention, rehabilitation and treatment aspects of the program

are implemented by a three track system under the auspices of the Army Medical Department. It must be pointed out that a great deal of the prevention aspects of the program are provided by ADAPCP Educational Coordinator.

Track I provides alcohol and other drug awareness education and is primarily preventive in nature. This track is designed as an educational approach to behavior change. An individual identified as needing Track I care will be enrolled by the unit Commander in the ADAPCP for this service which will last not more than 30 days. During Fiscal Year 1984, 142 soldiers or 41 percent of all Ft Leonard Wood ADAPCP admissions were enrolled in Track I. This compares to an Army-wide figure for the same FY of 17,259 soldiers or 40 percent.²

Track II is a more intensive effort that includes individual, group, and family counseling. These services are provided in an outpatient or nonresident setting. The education sessions of Track I are available in this track also. Enrollment in this track will be for not less than 30 days and not more than 360 days. During FY 84, 202 individuals or 58.4 percent of all Fort Leonard Wood ADAPCP admissions were enrolled in Track II. This compares to an Army-wide figure for the same FY of 24,723 individuals or 57.3 percent. This track will be the focus of the research effort.³

Track III is the most intensive effort and involves individuals who are dependent on alcohol or other drugs. Enrollment requires inpatient residential treatment of 6 weeks and follow-up as an outpatient, utilizing basically the same treatment techniques as Track II, for a period of

one year. During FY 84, 2 individuals or .6 percent of ADAPCP enrollments obtained this type of treatment. This compares to 932 or 2.2 percent Army-wide.⁴

Enrollment in the ADAPCP is determined by the unit Commander after an evaluation has been made of the soldier by an ADAPCP counselor. Enrollment is based on the Commander indicating that he suspects or identifies an individual as being involved with alcohol to the extent that it is interfering with duty performance or involves some breach of discipline. Any involvement with illicit drugs is grounds for referral and enrollment. In some cases, the soldier realizes that help is needed with an alcohol or other drug problem and voluntarily seeks help. Nevertheless, the Commander is the enrolling authority.

Upon completion of treatment the counselor either recommends to the Commander that the soldier be retained on active duty or separated. Using this recommendation and the soldiers duty performance, the unit Commander makes the final determination on retention or separation. If the individual is retained, he/she is released from the program and returned to duty. If the individual is to be separated, the Commander must take appropriate administrative discharge action. The individual is considered to be a success (see Appendix A) if he/she is retained on active duty upon completion of treatment. Likewise a soldier is considered a failure (see Appendix A) if he/she is to be separated from active duty. This determination is made at the time of release from the treatment program. In FY 1983, 49,135 individuals were treated Army-wide in all Tracks of the ADAPCP. 35,291 or 71.8 percent were successful and 13,844 or 28.2 percent were failures.⁵

The number of soldiers treated in the ADAPCP for FY 1983 make-up the equivalent troop strength of slightly more than three heavy divisions. Troop strength equivalent for successes is slightly more than two divisions and failures at slightly less than one heavy division. That number of losses is significant when a dollar replacement cost for accession and training of new soldiers is applied. It has been conservatively estimated that it cost approximately \$8,900 per soldier to perform those functions.⁶ The cost avoidance to the Army of successful ADAPCP rehabilitation is calculated as the number of program successes times the cost to replace the soldier minus total program costs. In 1983, it was estimated that \$212.2 million was saved because of the rehabilitation program operated by the ADAPCP.⁷

Justification For The Research Effort

While the ADAPCP pays for itself in terms of dollars expended or saved, the true measure of a successful treatment program is how the soldier performs after treatment. If there are significant losses after treatment, then the premises that the ADAPCP is a manpower conservation program or that the Army is saving significant amounts of appropriated funds as a result of treatment are false. To date, those premises are based on the successes, as determined by the unit Commander after consultation with the ADAPCP counselor, on the day of program discharge. Army policy makers in Washington, D.C. have also recognized the need to track these successes through an automated system. Such a system, the Drug and Alcohol Management Information System (DAMIS), is being prepared to track these soldiers. However, the DAMIS system has not tracked the Track II successes. As far as can be ascertained this is

the first attempt to follow or track individuals after their treatment in Track II to determine if they are still free from the effects of alcohol or other drugs and if their duty performance is still satisfactory as determined by the unit Commanders.

Statement of Research

The purpose of this research is to determine if Track II treatment for alcohol and drug abuse provided by the Fort Leonard Wood ADAPCP is successful six months after discharge from treatment.

Objectives

The primary objectives of this study are as follows:

1. Identify, through the client case files, personnel who have received Track II treatment during the second quarter of CY 1984.
2. Determine the reason for enrollment in the ADAPCP, either alcohol or drug. While polydrug use may be indicated, the primary use as listed on the intake record will be recorded as reason for enrollment.
3. Determine success rates at time of discharge from the program.
4. Determine, after six months, if the same individuals are still successful.
5. Analyze data using appropriate descriptive statistical techniques.

A secondary objective will be to analyze demographic data in a descriptive manner as it relates to individuals treatment outcome.

Criteria

The criteria upon which the research is based is as follows:

1. Follow-up success will be determined based on retention on active duty after six months.
2. At least 75 percent of all individuals released successfully from Track II must still be on active duty six months after treatment in order for the Fort Leonard Wood ADAPCP Track II treatment program to be considered successful.
3. Hypothesis testing (t-test and Chi square) at the .05 level of significance will be employed to determine if there are differences in treatment outcomes.

Assumptions

1. That Commanders place individuals in Track II to receive rehabilitation in accordance with Army Regulations.
2. That soldiers who have permanent changes in station (PCS) following treatment will be considered successes.
3. That the clinical staff are providing prescribed therapeutic techniques.
4. That the success rate for clients with alcohol problems is higher from clients with drug problems due to the Army's tougher stance against drug use.

Limitations

1. The study will be restricted to active duty permanent party personnel at Fort Leonard Wood. The study, however, could be replicated at any installation with an ADAPCP.

2. Individuals will be followed for six months to determine if they are still successful. A more in depth study could follow the individuals for a much longer period of time, as per the future DAMIS project, but due to the transient nature of the military the number to track on any one installation would soon be reduced to zero.

Literature Review

A number of journals are dedicated solely to research and the thoughts of numerous authors from around the world who deal with the treatment of alcohol and drug users and alcoholics and drug addicts. A significant amount of literature measures the impact of alcohol and drugs in the military. Unfortunately, there is a dearth of information dealing specifically with treatment outcomes related to success and failures at a local ADAPCP. Nevertheless, a review of literature that relates to Armed Services, primarily the Army, will be made. Additionally, review of some literature concerning recidivism among the civilian population will be made. Great care will be made to not make comparisons that are inappropriate due to the differences in the populations that are the focus of various studies, that is civilian versus military.

One of the great struggles that the Army leadership has faced is how to handle the alcohol problem. The ability to drink heavily has become synonymous with toughness and masculinity. Numerous social events have been set up where the expectation is to party, drink and let off steam. Fortunately these perceptions are changing.

In 1976, the General Accounting Office (GAO) reported that in the Army 32 percent of the enlisted men and 20 percent of the officers were either heavy or binge drinkers and an additional 35 percent of the enlisted and 17 percent of the officers had drinking problems.⁸ How to overcome those problems required imagination and leadership. Attempts to educate, prevent, and rehabilitate became the watchwords upon which the Army responded to the alcohol and drug problem.

While early attempts were made to curb the intemperate use of alcohol, the major impetus for today's ADAPCP came as a result of drug use. The Vietnam Era Army brought the attention of the entire country upon the use and impact of drugs in the Armed Services. However, this carried over into the 1980's, even after the appearance of the ADAPCP. The Deputy Assistant Secretary of Defense of Health Affairs (Drug and Alcohol Abuse) said cannabis was the second biggest problem facing the military (after alcohol). Twenty-six percent of tested military personnel used cannabis in the previous 30 days including 37 percent of the younger enlisted personnel.^{9,10} As a result, significant resources were expended to increase laboratory testing for drugs of abuse with increased reliability. The focus was changed from identifying drug abusers and then referring for treatment to identifying drug abusers and taking punitive action against them. A policy mandated by the Department of the Army was implemented which required Commanders to take actions against their soldiers who were identified. The impact was felt almost immediately and drug useage dropped by over one-half. The message from DA was that drug useage is incompatible with continued military service.¹¹

In spite of this incompatibility, peer pressure continues to be one of the primary reasons for alcohol and drug abuse. Previous research has found peer pressure to be the key determinant for drug useage among males and females.¹²

With all the documented useage in our society, as well as the military, numerous programs have been implemented to prevent the problem. The military has lead the charge in this area and has expended millions of dollars on prevention programs. The results have been spotty at best. A study by the Air Force on the results of their preventive activities indicated that while those efforts increased general information awareness, heightened the drinking and driving issues, the results were by and large transient in nature. The program yielded changed attitudes but resulted in almost no changes in consumption.¹³

The services are rightfully concerned about alcohol and drug use and its impact on unit readiness. Every attempt is made to identify soldiers who are having difficulties with alcohol or drug use as early as possible and to treat them or eliminate them from the service. This may be one of the reasons why so many people are enrolled in the Track I and II programs and so few in Track III. In the civilian community, most employers do have not as much control as the military has over its members. Most of the studies in the civilian and military communities deal with individuals who are diagnosed as alcoholic or drug addicts. The bulk of the treatment outcomes deal with these groups rather than with those who are using alcohol and drugs intemperately.

There have been studies of the Navy's inpatient program on predicting success for alcoholics. The results indicate that treatment outcome is directly related to the level of military status, this is length of service and grade. Those who are career oriented were returned to duty more often, at a rate of 64 percent.¹⁴ Since the Track II individual is not generally an alcoholic, the success rate should be slightly higher, hence the 75 percent criteria rate used to evaluate the Fort Leonard Wood program. Secondly, the Navy has the same control of their service members as the Army, therefore the results should be somewhat the same for the Track III inpatient program.

In the civilian community, a number of treatment follow-up studies have been completed. However, these studies have raised a number of methodology questions. First, the traditional reliance on abstinence as the sole criterion of treatment success is probably misguided. That criteria may be absolutely appropriate for alcoholics and some alcohol abuser but is probably not appropriate for all completing a Track II program. Second, there is great difficulty in locating alcoholics for follow-up treatment. In the military we have much greater control over our population and follow-up is a little easier until the individual moves to another location. Yet even then, given enough time, a mechanism is available to follow any Army member.

Several studies have been conducted on recidivism rates and which factors correlate to those rates. Punitive action, such as going to jail, losing a drivers license, being fired or receiving some other financial burden had no effect in changing the recidivism outcome. Once

again, as with the Navy study cited earlier, one's status, that is income and position in the community, was a good predictor of treatment results if associated with the presence of a car accident or some other public display.^{16,17,18} This generally correlates to the military community since status and military rank impacts on the career of the service member. The Army tends to forgive the junior soldier for his/her alcohol or drug intemperance, but a career soldier has a great deal to lose if identified as a repeat offender, particularly in the alcohol abuse area. Drug abuse among career soldiers is simply not tolerated.

Reenrollment in the ADAPCP is possible on rare occasions but usually only after careful reexamination of the soldier by the Counselor and Commander for future service benefits. The civilian community has studied the reasons for reenrollment in the treatment program. Results have provided little upon which to base a prediction for readmission with one exception. That exception is any intemperate use that caused some "audience reaction", such as the report of a traffic accident in the newspaper, radio, television, could result in a repeat enrollment. Such a report would likely label a person so that they would be considered a failure.¹⁹

The effectiveness of treatment in the civilian community, the scope of this study in the military, has been studied by several researchers. Those studies attempted to examine the patient's improvement after substance abuse treatment and to what extent the improvements are due to the effects of treatment. The results were that patients do improve after treatment and as a direct result of the treatment process.^{20,21,22}

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Research Methodology

The ADAPCP maintains client case files for all individuals who have been enrolled for treatment. These case files are retained for one year following release of the individual from the program. During the last week of September 1984 the closed case files were examined and all Track II individuals who had been enrolled and had been released from the treatment program during the second quarter of calendar year 1984 (April, May and June) were identified. All active duty individuals released from the ADAPCP during these months, either as successes or failures, are in the follow-up study. The primary focus of the follow-up study are those individuals who were determined as successes. The failures were followed to determine if the unit Commander did, in fact, complete the administrative discharge procedure.

Part A of the Data Collection Sheet (Appendix B) was completed for each individual identified. All demographic data, including the reason for enrollment was determined from DA Form 4465, ADAPCP Client Intake Record (Appendix C). The data collected includes grade, length of treatment, reason for enrollment, age, sex, educational level, place of residence, disposition of individual following treatment.

One of the major concerns of the researcher was to ensure the confidentiality of individuals was maintained. Once the name and demographic information was placed on the Data Collection Sheet, it was secured and safeguarded in accordance with the same requirements as all client information of the ADAPCP. Data Collection Sheets were locked in a filing cabinet and then locked in an office. No other person had access to

these sheets except the researcher. The unit Commander or the unit First Sergeant were the only individuals that had any follow-up questions directed to them.

The Success Rate was determined from information collected from block 12, DA Form 4466, ADAPCP Client Progress Report, indicating client disposition. Total successes divided by total individuals enrolled equals success rate. This data is the base from which the follow-up study will be conducted.

Six months following discharge from the program, plus or minus five days, the unit Commander was personally contacted and data was collected using the Part B of the Data Collection Sheet. All data for follow-up was collected during the months of October, November and December 1984. Follow-up success rate will be determined as follows: Total follow-up successes divided by total successes equals follow-up success rate.

Once treatment outcomes are determined they will be compared against stated criteria. Additionally, success and failure rates will be examined to see if differences exist between the two groups, successes and failures, utilizing the demographic variable collected on the Data Collection Sheet.

Finally, a discussion will be made concerning the results of the rates and the comparisons of treatment outcomes utilizing descriptive statistics of percentage, mean, mode, range and t-test and Chi-square test.

Footnotes

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II. DISCUSSION

The Data Base

The closed client case files are filed according to month of discharge from the ADAPCP. All records filed in the months of April, May and June 1984 were examined. The months of March and July 1984 were also reviewed to find any case files that may have been inadvertently filed. The search through the files located a total of 46 case files for soldiers who had been enrolled in Track II. One case file was later discovered to be that of a trainee and was eliminated from the follow-up study leaving 45 permanent party cases to follow.

Of the 45 individuals released during the subject period, 27 individuals were retained on active duty by the Commander for a 60 percent success rate and 18 of 45 or 40 percent were failures and were to be separated from the service.

It should be noted that the 60 percent success rate appears low when compared to figures provided earlier from 1983 data of 71.8 percent success rate reported by DA. However, those figures were for all tracks Army-wide, and the 60 percent success rate experienced at Fort Leonard Wood were only for Track II during one quarter. It must also be noted, that from previous experience, very few individuals are considered failures from Track I due to the treatment approach being primarily preventive in nature. Since the success rate for Track I is very high and when averaged with the lower Track II percentages this would

increase the total Army-wide percentage. While an additional study could be done in this area, the differences between the 71.8% success rate Army-wide for all tracks can be partially accounted for when compared with the 60 percent rate for Track II at Fort Leonard Wood.

The sample population included the following data:

Table 1: Grade Structure by Treatment Outcome

<u>GRADE</u>	<u>SUCCESSSES</u>	<u>FAILURES</u>	<u>TOTAL</u>
E-1	3	2	5
E-2	4	3	7
E-3	6	6	12
E-4	5	5	10
E-5	3	1	4
E-6	3	1	4
E-7	<u>3</u>	<u>0</u>	<u>3</u>
TOTAL	27	18	45

This grade structure display indicates that the bulk of the enrollment, 75 percent ($34 \div 45$), are E-4 or below. However, when examining that same group, E-4 or below, for successes and failures that data indicates that only 52.9 percent ($18 \div 34$) are successes while 47.1 percent ($16 \div 34$) are failures. Conversely, percentage wise the E-5 and above do much better in treatment, 81.8 percent ($9 \div 11$) for successes and only 18.2 percent ($2 \div 11$) for failures.

Since unit Commanders have the greatest weight in determining success or failure, this data must be looked at from his/her perspective. The E-4 or below is not necessarily identified as a career

soldier. Based on youth and lifestyle approach, the Commander may be a little quicker to judge the soldier a failure. Secondly, the soldiers attitude concerning the use of alcohol and drugs is probably one of the more telling aspects to success and failure. If the soldier makes the decision that he wants to continue in his current behavior rather than to "soldier" free from the effects of alcohol and other drugs, the Army will be quick to return the individual to civilian life. In the more senior soldier, the job, the opportunity to provide a relatively comfortable living, becomes the major factor in the soldiers desire to be successful. The treatment program personnel use that leverage effectively in dealing with career soldiers.

The mean age of the sample population is 25.3 years, with a standard deviation of 6.02 years. The range is from 19 years to 41 years with a mode of 21 years. The breakdown of successes and failures also indicates some similarities to the grade structure where there tends to be a natural correlation of soldiers increasing grade to increasing age. The successes mean age is 26 years with a standard deviation of 6.31 years and a range of 19 years to 41 years. The failures on the other hand have a mean age of 24.3 years, with a standard deviation of 5.28 years. The range of the failures is 19 years to 40 years. Once again the more junior person, age wise, is more likely to be a failure just as the more junior grade person would more likely be a failure in treatment.

The reason for enrollment and the outcomes of treatment is an interesting part of the study. Of the 45 individuals treated, 31 were

treated for alcohol and 22 were considered a success and 9 were failures. Of the 14 treated for drugs, 5 were considered successes and 9 were considered as failures. This study indicates that there is a difference between treatment outcomes when comparing alcohol and drugs.

Table 2: Treatment Outcomes by Alcohol or Drugs

	Treatment Outcomes		
	Successes	Failures	Total
Alcohol	22	9	31
Drug	5	9	14
Total	27	18	45

A Chi Square (χ^2) test will be utilized to test the null hypothesis. Hypothesis. H_A : There is a difference in treatment outcomes, success or failure, for alcohol or drugs.

Null Hypothesis. H_0 : There is no difference in treatment outcomes, success or failure, for alcohol or drugs.

$$\chi^2 = \frac{(O-E)^2}{E}$$

$$\chi^2 = \frac{(22-18.6)^2}{18.6} + \frac{(9-12.4)^2}{12.4} + \frac{(5-8.4)^2}{8.4} + \frac{(9-5.6)^2}{5.6}$$

$$\chi^2 = .6215 + .9323 + 1.3762 + 2.0643$$

$$\chi^2 = 4.99$$

With a significance level $\alpha = .05$, $df=1$, the critical value is 3.84. Since the computed value is larger, 4.99, than the critical value, the

null hypothesis is rejected. It must be concluded that there is a difference in treatment outcomes of individuals involved in alcohol or drugs.

These results are not surprising. The higher success rates for alcohol treatment may, in fact, represent the more tolerant attitudes of the Army and our society to alcohol use. Since the use of drugs is generally an illegal activity, the Army has a much stronger stance towards those who are identified as drug abusers. Unit Commanders have been given greater tools to identify individuals who use drugs through the urinalysis program. Additionally, mandated actions have been prescribed by the Department of the Army to eliminate individuals who are identified as drug users. This policy is widely published so that all soldiers know where the Army stands and the policy is intended to be a deterrent to the use of drugs. However, the policy is also well known by ADAPCP counselors and unit Commanders who collectively must decide the soldiers treatment outcome. Their perceptions of how the Army wants drug abusers handled must certainly account for some of the difference in the treatment outcomes.

The length of treatment that an individual undergoes is also an area that was examined. Length of treatment was measured from the time the individual was enrolled in the ADAPCP until the individual was released and is measured in days. What was not examined was the intensity of treatment. Intensity is the frequency of treatment, the type of sessions held, either individual, group or a combination of both and the skill level of the counselor providing the treatment. Those areas could only be determined by an intense review of each client's case file.

In order to determine if length of treatment made a significant difference in determining treatment outcomes, a test of the hypothesis that there was no difference between the means of the samples was conducted.

TABLE 3: Length of Treatment

	<u>Success</u>	<u>Failure</u>
Mean	213.26 days	189.33 days
Standard Diviation	91.63	117.43
Variance	83.96	137.89

Prior to determining whether the length of treatment makes a significant difference in treatment outcome, it is necessary to assume an equality of variances. To test that assumption an F-test is used.

Hypothesis. H_A : The variances in treatment outcomes between success and failures are not equal.

Null Hypothesis H_0 : The variance in treatment outcomes between success and failures are equal.

The degree of freedom for successes is $27-1=26$; for failures $18-1=17$. At the .05 level of significance, the critical value of $F=2.15$.

$$\text{Calculated } F = \frac{VF}{VF}$$

$$F = \frac{137.89}{83.96}$$

$$F = 1.64$$

The calculated statistic does not exceed the critical value at the .05 level. Therefore, the null hypothesis is accepted. It is assumed that the variances of the two populations, successes and failures, are equal.

Since the sample sizes are small, less than 30 individuals, a t-test is used. At the .05 level of significance with a two tailed test, the critical value is 2.02.

Hypothesis. H_A : There is a difference in treatment outcomes due to length of treatment.

Null Hypothesis H_0 : There is no difference in treatment outcomes due to length of treatment.

$$t = \frac{\bar{X}_s - \bar{X}_f}{\sqrt{\frac{V_s + V_f}{n_s + n_f - 2} \left(\frac{1}{n_s} + \frac{1}{n_f} \right)}}$$

$$t = \frac{213.26 - 189.33}{\sqrt{\frac{8396 + 13789}{27 + 18 - 2} \left(\frac{1}{27} + \frac{1}{18} \right)}}$$

$$t = \frac{23.93}{\sqrt{47.77}}$$

$$t = \frac{23.93}{6.91}$$

$$t = 3.462$$

The calculated statistics exceeds the critical table value at the .05 level. Therefore, the null hypothesis is rejected. There is a difference in treatment outcomes due to length of treatment.

Statistically, treatment outcomes appear to be significantly related to length of treatment. However, DA policy has been and continues to be to identify those individuals who appear to or will be unsuccessful, as early as possible, in the treatment process and eliminate them. The goal is during the first sixty to ninety days. The failures mean length of treatment was slightly more than six months. The Ft Leonard Wood ADAPCP works with the individual much longer before determining disposition.

Additional studies could be made to determine if the failure rate would decrease if the length of treatment for individuals considered failures was extended to the same number of days as successes. While length of treatment may be a significant factor in treatment outcomes, there may be other factors just as significant which influence those outcomes.

The Education level of the individuals in the sample is as follows:

TABLE 4: Level of Education

	<u>n</u>	<u>%</u>	<u>Success</u>	<u>%</u>	<u>Failure</u>	<u>%</u>
College Graduate	0	0	0	0	0	0
Some College	5	11	3	11	2	11
HS Graduate/GED	28	62	17	63	11	61
Some High School	12	27	7	26	5	28
Less than HS	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
TOTAL	45	100	27	100	18	100

Education level remains constant throughout the sample. Almost no variation exists between successes and failures.

Marital Status of those enrolled in the ADAPCP from the sample is as follows:

TABLE 5: Marital Status

	n	%	Success	%	Failure	%
Never Married	28	62.2	16	59.3	12	66.7
Now Married	14	31.1	9	33.3	5	27.8
Divorced	2	4.4	1	3.7	1	5.6
Separated	<u>1</u>	<u>2.2</u>	<u>1</u>	<u>3.7</u>	<u>0</u>	<u>0</u>
	45	99.9*	27	100.0	18	100.0

*Percentage less than 100 percent is due to rounding.

Marital Status, like the educational level, remains quite constant throughout the sample. There are slightly more individuals, percentage wise, who have never been married who are failures than for successes. Since support groups and one circle of friends does impact on an individual's behavior, there may be some differences in this area that may warrant further study at a later date.

The place of residence for soldiers enrolled in the ADAPCP is as follows:

TABLE 6: Place of Residence

	n	%	Success	%	Failure	%
Barracks	32	71.1	18	66.7	14	77.8
BEO	1	2.2	1	3.7	0	0
On Post Housing	10	22.2	6	22.2	4	22.2
Off Post Housing	<u>2</u>	<u>4.4</u>	<u>2</u>	<u>7.4</u>	<u>0</u>	<u>0</u>
	45	99.9*	27	100.0	18	100.0

*Percentage less than 100 percent due to rounding.

The barracks is the primary place of residence for individual enrolled in the ADAPCP. This is not surprising given the grade and age of the sample. Once again, the support group that exists among family and friends is significant in most peoples lives. The slightly higher percentage of barracks failures than successes could be attributed to the close association of individuals who succumb to peer pressure to become a part of the group.

Follow-Up

Of the 45 individuals in the Track II sample, 18 were considered failures at the end of treatment and were to be separated from the service. Previous experience of the researcher had been that at some installations the Commander would state that the individual was a failure but did not separate for a variety of reasons. The 18 failures at Ft Leonard Wood were followed to see if the Commander did, in fact, consider the individual as failures and to see if the soldiers were still in the unit or separated.

Six months past treatment all 18 individuals had been separated from the service. Fifteen of the 18 had been separated as a result of specific administrative action taken by the Commander. The other 3 individuals separated at their normal expiration of term of service (ETS) date. The key point to be made is that all individuals who had been considered rehabilitative failures by the counselors and Commanders were separated from the service one way or another in accordance with Army policy.

The primary focus of the study was to follow all the individuals who were released from Track II as successful. Of the 45 individuals enrolled in the second quarter CY 1984, 27 were declared a rehabilitative

success and returned to duty, 60 percent success rate. Six months following their discharge, a visit was made to the unit Commander or First Sergeant to complete Part B of the Data Collection Sheet, at Appendix B. All follow-up contacts were made within the specified time frame of plus or minus five days of the six month anniversary of release from the program except two. Those two contacts were not made due to the unit being in a field training exercise away from the installation. The unit Commanders were contacted for these cases within two days of return from the field exercise and both follow-ups were completed less than two weeks late. Neither case had any impact on the follow-up study.

Of the 27 individuals in the follow-up study, 19 were still on the installation and at their place of work. Three individuals had left the installation under permanent change of station (PCS) order. Unit Commanders stated that these three had been performing satisfactorily in their jobs and did not appear to be having problems with alcohol or drugs. In accordance with stated criteria, these three cases will be considered as successes since they are still in the service, only at another location.

The remaining five soldiers had left the service on their normal ETS date. While these individuals may have been treatment successes at discharge from the ADAPCP and continued successfully on their jobs until their ETS date, for the purpose of this study they will be considered failures since they are no longer providing productive service to the Army. While that may be a conservative approach, it appears reasonable since the goal of the ADAPCP is manpower conservation. It is granted

that some if not all of these individuals may be treatment successes but there is not a way to track them to ensure that that assumption is correct.

It is interesting to note the demographics of the five soldiers considered failures in the six months follow-up study. Three were enrolled for alcohol and two for drugs. The mean age was 23.2 years, slightly more than a year younger than the base group failures. Four of the five were male. Mean length of treatment was 239.8 days, 50 days more than the base group failures and 25 days more than the base group successes. Four of five had never married and four of five were high school graduates or had some college. Four of the five lived in the barracks. Their separation from service at the ETS date may have been a normal life experience change, not uncommon at that age.

Six month post treatment follow-up indicates that 22 of 27 individuals were still in the service and performing at a satisfactory level with a success rate of 81.5 percent ($22 \div 27$). This is above the 75 percent stated as a criteria for the Fort Leonard Wood ADAPCP Track II treatment program to be considered successful.

An 81.5 percent success rate or conversely an 18.5 percent recidivism rate is very difficult to compare to other civilian studies. Very few civilian programs deal with the group of individuals that the Army targets in Track II. Most recidivism studies completed in the civilian community deal with diagnosed alcoholics and/or drug addicts as stated in the literature review. Track II individuals generally do not fall into that category. Comparisons with other installation's Track II

personnel, six months past treatment, would be the only fair comparison that could be made. That information could be obtained by replicating this study at another installation.

One last comparison must be made, however. While 22 of 27 individuals were considered successes in the six month follow-up study, a comparison of the 22 success to the total enrolled in Track II six months previously must be made. Twenty-two of 45 or 48.9 percent of all permanent party individuals originally enrolled in the ADAPCP Track II program were successfully rehabilitated, slightly less than half. Is that success? That question can only be answered by those who control the resources, dollars and manpower. Given the information previously cited, it would appear that even with that success rate, there is a cost benefit gained by the Army to continue the treatment program. The Army might find it difficult to access the equivalent of more than two divisions who are already free from the effects of alcohol and drugs. At least with a treatment program, we are dealing with a group who have some experience and longevity in military service, a group that is hard to replace.

CONCLUSION

The ADPCP Track II treatment program at Ft Leonard Wood is a successful program based on the criteria of this study. The entire Army program is complex and deals with broad social issues that are still being wrestled with by our society. What is the most effective way in dealing with alcohol and other drugs? The treatment program is an attempt to assist those who have succumbed to the effects of these drugs. The Army is making great strides in preventing or at least curbing and limiting the problems that inevitably result in referral to the treatment programs.

The treatment process does make a significant impact into the lives of the individuals who are being treated. Unit Commanders expressed great appreciation for the changes that they see in soldiers who are treated in the ADAPCP. The change in some soldiers is great, in others almost imperceptible, and in others sometimes a change for the worse. While the Army has always espoused an approach to help change the lives of those who desire and want it, it also made it clear that it will assist those who do not want help or assistance to leave the service as expeditiously as possible.

This study was an attempt to follow soldiers who had been identified by their unit Commanders as needing help. A number responded and are still in the service, much to the benefit of the Army and the individual. A like number failed to respond to the treatment process and were eliminated, also to the benefit of the Army.

While the ADAPCP has impacted on a great many lives, very little has been studied concerning the results of the treatment. As cited throughout this study, a great many areas could be the focus of additional research. It would be most interesting and perhaps informative to repeat this study at another installation.

DEFINITIONS

Success Success is when the individual has continued useful service as a result of progress in treatment and is to be retained on active duty.

 The Commander determines based on duty performance and conduct, nonduty performance and conduct, abstinence from alcohol and other drugs of abuse, and personal motivation to overcome the effects of alcohol or other drugs.

Failure When the Commander determines that duty performance and progress is unsatisfactory and cannot justify further rehabilitation efforts in the military resulting in separation from the service.

APPENDIX A

DATA COLLECTION SHEET

PART A

Name:

Grade:

Unit:

Date of Enrollment:

Date of Discharge:

Length of Treatment:

Enrolled For (Circle One)

Alcohol

Drug

Age:

Sex:

Education Level: (Circle One)

College Grad

Some College

HS Grad/GED

Some High School

1-8 Grade

Marital Status: (Circle One)

Never Married

Now Married

Divorced

Separated

Current Residence: (Circle One)

Barrack

BEQ

BOQ

On Post Housing

Off Post Housing w/Dep

Off Post Housing w/o Dep

Disposition: (Circle One)

Retention on Active Duty

Separation

PART B

6 Month Follow Up With Commander

Soldier Still in Unit?

Yes

No

If No, Reason: (Circle One)

PCS

ETS

Other (Specify)

CDR/1SG COMMENTS:

APPENDIX B

FOR LOCAL USE ONLY

CLIENT'S NAME

UNIT/OFFICE

ADAPCP CLIENT INTAKE RECORD (CIR)

For use of this form, see AR 600-85, the proponent agency is DCSPER

REQUIREMENT CONTROL SYMBOL

CSGPA-1400(R1)

SEE REVERSE SIDE FOR PRIVACY ACT STATEMENT

1. DATE OF ENROLLMENT a. _____ (Yr Mo Day) b. <table border="1" style="display: inline-table; width: 100px; height: 20px; vertical-align: middle;"></table> (Julian Date)		2. SERVICE AREA CODE a. <table border="1" style="display: inline-table; width: 100px; height: 20px; vertical-align: middle;"></table> (Initial MTF) b. <table border="1" style="display: inline-table; width: 100px; height: 20px; vertical-align: middle;"></table> (Current Area)		3. CLIENT'S ID CODE <table border="1" style="display: inline-table; width: 200px; height: 20px; vertical-align: middle;"></table>																															
4. SVC MEMBER GRADE a. _____ (Rank) b. <table border="1" style="display: inline-table; width: 100px; height: 20px; vertical-align: middle;"></table> (Grade Code)		6. DIAGNOSTIC CODES <table border="1" style="width: 100%; height: 100px; vertical-align: top;"> <tr><td>a.</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>b.</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>c.</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>d.</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>e.</td><td></td><td></td><td></td><td></td><td></td></tr> </table>		a.						b.						c.						d.						e.						7. CLIENT'S STATUS (Check one box only.) a. <input type="checkbox"/> Army AD/ADT c. <input type="checkbox"/> ARNG h. <input type="checkbox"/> Dep Ret/Dec Mil i. <input type="checkbox"/> Dep DOD Civ Empl k. <input type="checkbox"/> Ret Military b. <input type="checkbox"/> Other Mil Svc (Specify) _____ d. <input type="checkbox"/> USAR f. <input type="checkbox"/> Other DOD Civ Empl g. <input type="checkbox"/> DA/NAF Civ Empl j. <input type="checkbox"/> Dep AD Mil l. <input type="checkbox"/> Foreign National e. <input type="checkbox"/> DA/NAF Civ Empl g. <input type="checkbox"/> Dep AD Mil i. <input type="checkbox"/> Dep DA/NAF Civ Empl l. <input type="checkbox"/> Foreign National	
a.																																			
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e.																																			
5. CIV EMPLOYEE GRADE <table border="1" style="display: inline-table; width: 100px; height: 20px; vertical-align: middle;"></table>																																			
8. PHYSICIAN DIAGNOSIS/BASIS FOR ENROLLMENT a. _____ b. _____ c. _____ d. _____ e. _____		9. NAME OF MED TREATMENT FACILITY (MTF) (Type or print) _____		10a. NAME AND GRADE OF PHYSICIAN (Type or print) _____																															
11. CLIENT'S YEAR OF BIRTH (YOB) <table border="1" style="display: inline-table; width: 100px; height: 20px; vertical-align: middle;"></table>		12. RACE <input type="checkbox"/> Cau <input type="checkbox"/> Negro <input type="checkbox"/> Other		13. SEX <input type="checkbox"/> Male <input type="checkbox"/> Female																															
14. EDUCATION a. <input type="checkbox"/> College Graduate d. <input type="checkbox"/> Some High School b. <input type="checkbox"/> Some College c. <input type="checkbox"/> HS Graduate/GED e. <input type="checkbox"/> 1-8 Grade		15. MARITAL STATUS a. <input type="checkbox"/> Never Married b. <input type="checkbox"/> Now Married d. <input type="checkbox"/> Separated e. <input type="checkbox"/> Widowed c. <input type="checkbox"/> Divorced		16. LENGTH OF SERVICE a. _____ (Years) b. <table border="1" style="display: inline-table; width: 100px; height: 20px; vertical-align: middle;"></table> (LOS Data Code) c. <table border="1" style="display: inline-table; width: 100px; height: 20px; vertical-align: middle;"></table> (LOS Present Unit)																															
17. PMOS OF SVC MEMBER a. <table border="1" style="display: inline-table; width: 100px; height: 20px; vertical-align: middle;"></table> b. Performing in PMOS <input type="checkbox"/> Yes <input type="checkbox"/> No																																			
18. PREVIOUS ALCOHOL OR DRUG COUNSELING/REHABILITATION a. <input type="checkbox"/> Army b. <input type="checkbox"/> None c. <input type="checkbox"/> Other (Specify) _____		19. CONSENT OF CIV EMPL TO RELEASE INFO TO SUPERVISOR <input type="checkbox"/> Yes <input type="checkbox"/> No		20. CLIENT'S DISCIPLINARY RECORD (Alcohol or Drug Related) <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th>Civilian</th> <th>No.</th> <th>Military</th> <th>No.</th> </tr> <tr> <td>a. Arrests</td> <td></td> <td>c. Articles 15</td> <td></td> </tr> <tr> <td>b. Convictions</td> <td></td> <td>d. Courts Martial</td> <td></td> </tr> </table>		Civilian	No.	Military	No.	a. Arrests		c. Articles 15		b. Convictions		d. Courts Martial																			
Civilian	No.					Military	No.																												
a. Arrests		c. Articles 15																																	
b. Convictions		d. Courts Martial																																	
21. SVC MEMBER'S RECORD OF AWOL Total Number of AWOL Episodes: _____		22. SVC MEMBER'S ETS DATE a. (Yr - Mo - Day): _____ b. Julian Date <table border="1" style="display: inline-table; width: 100px; height: 20px; vertical-align: middle;"></table>		23. CLIENT'S PRESENT RESIDENCE a. <input type="checkbox"/> Army Barrack d. <input type="checkbox"/> On-Post Housing e. <input type="checkbox"/> Off-Post Housing w/Dep f. <input type="checkbox"/> Off-Post Housing w/o Dep b. <input type="checkbox"/> BEQ c. <input type="checkbox"/> BOO																															
24. CASE FINDING METHOD <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th>Bio-Chemical</th> <th>Non-Bio-Chemical</th> </tr> <tr> <td>a. <input type="checkbox"/> Cdr Dir c. <input type="checkbox"/> Rehab Staff d. <input type="checkbox"/> Other local testing</td> <td>e. <input type="checkbox"/> Self Ref g. <input type="checkbox"/> Supv Ref h. <input type="checkbox"/> Inves/App i. <input type="checkbox"/> Med Ref f. <input type="checkbox"/> Cdr Ref</td> </tr> </table>						Bio-Chemical	Non-Bio-Chemical	a. <input type="checkbox"/> Cdr Dir c. <input type="checkbox"/> Rehab Staff d. <input type="checkbox"/> Other local testing	e. <input type="checkbox"/> Self Ref g. <input type="checkbox"/> Supv Ref h. <input type="checkbox"/> Inves/App i. <input type="checkbox"/> Med Ref f. <input type="checkbox"/> Cdr Ref																										
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25. IMMEDIATE DISPOSITION a. <input type="checkbox"/> Track I b. <input type="checkbox"/> Track II c. <input type="checkbox"/> Track III d. <input type="checkbox"/> Holding for Track _____ e. Inpatient Detoxification: <input type="checkbox"/> Necessary <input type="checkbox"/> Unnecessary <input type="checkbox"/> Completed f. Utilization of Civilian Treatment/Rehabilitation Facilities: <input type="checkbox"/> Yes <input type="checkbox"/> No		26. DRUG/ALCOHOL USAGE PROFILE (Items a through k below must be accounted for by circling appropriate blocks)		27. TYPED NAME OF COUNSELOR _____																															
28. SIGNATURE OF COUNSELOR _____																																			
29. MILITARY MAILING ADDRESS OF ADCO _____		30. TYPED NAME OF ADCO _____		31. SIGNATURE OF ADCO _____																															

APPENDIX C

CLIENT'S NAME

UNIT/OFFICE

ADAPCP CLIENT PROGRESS REPORT (CPR)

For use of this form, see AR 600-85; the proponent agency is DCSPER.

REQUIREMENT CONTROL SYMBOL
CSGPA - 1400(R1)

SEE REVERSE SIDE FOR PRIVACY ACT STATEMENT

1. DATE REPORT IS DUE

a. _____
(Yr - Mo - Day)

b.

--	--	--	--	--

(Julian Date)

2. SERVICE AREA CODE

a.

--	--	--	--	--

(Initial MTF Code)

b.

--	--	--	--

(Current Area)

3. CLIENT'S ID CODE

--	--	--	--	--	--	--	--	--	--

4. ADD DIAGNOSTIC CODES

a.

5. REASON FOR REPORT (Check appropriate box) (For 1st, 2d and 3d CPR, complete Sec A and blocks 20 thru 22c only.)

a. ☐ Released from Program b. ☐ 1st CPR c. ☐ 2d CPR d. ☐ 3d CPR
e. ☐ 4th CPR (Reporting completed)
f. ☐ PCS Loss Report g. ☐ PCS Gain Report
h. ☐ Change of Track (See instructions for CPR)

SECTION A - CLIENT'S PROGRESS REPORTING

6. REHABILITATION METHODS USED SINCE INITIAL CIR OR LAST CPR (Check as many boxes as appropriate)

a. ☐ Awareness Education b. ☐ Individual Counseling c. ☐ Group Counseling
d. ☐ Antabuse e. ☐ Other Prescribed Medication f. ☐ Alcoholics Anonymous
g. ☐ Family Treatment h. ☐ Other (Specify) _____

7. CLIENT'S STATUS AS OF REPORT DATE (Check as many boxes as appropriate)

a. ☐ Track I b. ☐ Track II c. ☐ Track III
d. ☐ Holding for Track _____ e. ☐ In Confinement (Military or Civilian) f. ☐ AWOL 30 Days or Less (Service Member)
g. ☐ Other Hospitalization h. ☐ Other (Specify) _____

8. REHABILITATION FACILITIES USED SINCE INITIAL CIR OR LAST CPR (Check as many boxes as appropriate)

a. ☐ Military Inpatient Detoxification b. ☐ Military Residential Treatment (RTF Code:

--	--

)
c. ☐ ADAPCP Facility d. ☐ Other Civilian Facility

COMPLETE BLOCK 9 BELOW ONLY IF CLIENT IS RELEASED FROM PROGRAM

9. REASON FOR PROGRAM RELEASE (Check as many boxes as appropriate)

AD/ADT Army Service Member

a. ☐ Program Completed b. ☐ Expiration Term of Service
c. ☐ Other Honorable Discharge d. ☐ Administrative Discharge (Alcohol or drug related)
e. ☐ Less than Honorable Discharge f. ☐ AWOL 31 Days or More (DFR)
g. ☐ Retired h. ☐ Death i. ☐ USAR/ARNG ADT Completed j. ☐ Transferred to VA

Civilian Employee or Other Client

k. ☐ Program Completed l. ☐ Leaving Federal Service
m. ☐ Terminated from Federal Service (Alcohol or drug related) n. ☐ Transferring to Another Federal Agency
o. ☐ Refuses Further ADAPCP Services p. ☐ Leaving ADAPCP Service Area
q. ☐ Retired r. ☐ Death s. ☐ Other (Specify) _____

10. COUNSELOR'S ASSESSMENT OF PROGRESS DURING REHABILITATION

a. ☐ Progressing b. ☐ Not Progressing

11. COMMANDER'S APPRAISAL OF PROGRESS AND MILITARY EFFECTIVENESS

a. Efficiency: ☐ Satisfactory ☐ Unsatisfactory
b. Conduct: ☐ Satisfactory ☐ Unsatisfactory

12. ADAPCP RECOMMENDATION TO COMMANDER

a. ☐ Retention on Active Duty b. ☐ Separation

13a. TYPED NAME OF CLINICAL DIRECTOR/ COUNSELOR'S SUPERVISOR

13b. SIGNATURE

13c. DATE

SECTION B - MILITARY CLIENT'S DISPOSITION

14. COMMANDER'S ACTION:

a. ☐ Retention on Active Duty b. ☐ Separation

15a. TYPED NAME OF COMMANDER

15b. SIGNATURE

15c. DATE

SECTION C - PCS LOSS OR GAIN REPORT

16. DATE OF PCS LOSS

a. _____
(Yr - Mo - Day)

b.

--	--	--	--	--

(Julian Date)

17. LOSING AREA CODE

--	--	--

18. DATE OF PCS GAIN

a. _____
(Yr - Mo - Day)

b.

--	--	--	--	--

(Julian Date)

19. GAINING AREA CODE

--	--	--

20. REMARKS

21a. TYPED NAME OF COUNSELOR

21b. SIGNATURE

22a. MILITARY MAILING ADDRESS OF ADCO

22b. TYPED NAME OF ADCO

22c. SIGNATURE

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